CSHS - Health KiCC

Medical Condition Verification

Patient's Name:_____ DOB: _____

Parent's/Guardian's Name: _____

Chronic medical condition(s) of patient. (Chronic medical condition is defined as a condition that has existed or is expected to exist for two years or more, requires evaluation, consultation and medical treatment and is a coverable condition under the CSHS - Health KiCC program. A non-inclusive list of coverable conditions is on the back):

☐ Child has been diagnosed with the below:

☐ This is a referral for coverage under the 6 month diagnostic provision to identify if the child has the below diagnosis:

Name of diagnosis: _____ ICD 9 code: _____

Name of diagnosis: _____ ICD 9 code: _____

Name of diagnosis: _____ ICD 9 code: _____

Additional Comments:

_____

_____

_____

_____

_____

_____

Provider's Signature: _____ Date: _____

This form can be completed by any medical provider that has documentation of the above diagnosed condition(s) and could provide, upon request, such medical documentation.

Mail completed form to: CSHS-Health KiCC
600 E. Capitol Ave.
Pierre, SD 57501

or

FAX to: CSHS-Health KiCC
(605) 773-5683